

NATIONAL LABOR RELATIONS BOARD

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CAYUGA MEDICAL CENTER  
AT ITHACA, INC.

and

Cases 03-CA-185233  
03-CA-186047

1199 SEIU UNITED HEALTHCARE  
WORKERS EAST

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**CAYUGA MEDICAL CENTER'S  
BRIEF IN SUPPORT OF EXCEPTIONS**

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## **PRELIMINARY STATEMENT**

Put simply, this is a case of failing to see the forest through the trees. Two Cayuga Medical Center at Ithaca, Inc. (“CMC”) Intensive Care Unit (“ICU”) Registered Nurses (“RN”) were the subject of a patient-initiated complaint on September 11, 2016 (“9/11/16”). The two ICU nurses were Anne Marshall and Loran Lamb. The patient, who had received at least 22 previous blood transfusions at CMC which were administered by as many as 44 CMC nurses (two nurses for every transfusion), recognized that unlike every previous transfusion she had received at CMC, the transfusion on 9/11/16 was being administered by only one nurse (Ms. Marshall), unaccompanied by a second nurse to conduct the necessary verifications just prior to starting the transfusion. In the course of a thorough investigation into the patient complaint, Ms. Marshall and Ms. Lamb both admitted to deliberately failing to perform the two-nurse bedside verification which is:

- (1) the final and most critical safeguard to ensure the proper blood product is delivered to the patient because transfusion of the wrong product can quickly result in patient death;
- (2) required by CMC’s comprehensive Blood Product Administration Policy;
- (3) the National Safety Standard published by the Joint Commission;
- (4) the standard that all nurses are taught in nursing school everywhere; and
- (5) required at every healthcare facility in America.

Ms. Lamb never even bothered to enter the patient room. When Ms. Marshall began the process of starting the transfusion at the patient’s bedside all by herself, the patient questioned why the normal two-nurse verification process wasn’t being followed. Despite the patient’s expressed concern, Ms. Marshall refused to call a second nurse, and proceeded to start the infusion by herself. This put the patient at risk for a catastrophic adverse reaction that could have resulted in death. Blood transfusion errors cannot only kill the patient, but can destroy a

hospital's reputation, result in a crushing financial liability, and possibly lead to closure. As a result of the investigation, the two RNs were terminated.

Administrative Law Judge Sorg-Graves (the "ALJ") disregards these core facts in an attempt to minimize the severity of Ms. Marshall and Ms. Lamb's conduct and perpetuate a myth that this was some sort of elaborate "ruse" to remove Ms. Marshall, who was a known union proponent. In so doing, the ALJ refused to credit any testimony that did not fit into her theory. Indeed, the ALJ went so far as to suggest that the patient who voiced her concerns over the transfusion in question did not have a legitimate concern because the patient was in a "dark place" caused by the "stress of her illness." (Decision, p. 47)<sup>1</sup>. Accordingly, the ALJ failed to see that the only appropriate conclusion for any healthcare provider facing such circumstances would be to discharge the two RNs, as doing anything else would demonstrate a reckless disregard for the lives of their most vulnerable ICU patients.

The ALJ's decision is based primarily on two unsupported findings. First, that the failure to perform the two-nurse bedside verification was a widespread practice at CMC; a finding that is simply wrong.

Second, the ALJ downplays the severity of the misconduct by using a "No-Harm, No Foul" standard, justifying that the patient was never in real danger because the patient ended up receiving the correct blood despite the nurses' failure to follow policy. This cannot be the standard for a responsible healthcare institution because it would be tantamount to playing a game of Russian Roulette with human lives. We respectfully request that the Board, as it did in *Jackson Hospital Corp.*, 355 NLRB 643, 645 (2010), find that deliberate violation of a critical blood transfusion safeguard, where an error could result in a fatal outcome, warrants discharge, regardless of whether the violation actually results in harm to the patient.

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<sup>1</sup> Citations to the ALJ Decision are cited as Decision, p. \_\_\_\_, citations to General Counsel exhibits are cited as GC- \_\_\_\_, citations to Employer/Respondent exhibits are cited as R- \_\_\_\_, and citations to the Transcript are cited as Tr. \_\_\_\_.

CMC respectfully submits that the ALJ's decision in this case must be overturned to avoid setting a dangerous precedent for excusing wanton recklessness toward vulnerable populations so long as the individual engaging in the misconduct is a union proponent and no one actually dies.

### **STATEMENT OF FACTS**

CMC is an acute care hospital that serves the healthcare needs of Ithaca, New York and the surrounding communities. As an acute care facility, CMC administers blood products to patients in need multiple times a day. Blood product administration is considered a high-risk medical procedure because transfusing the wrong blood product can quickly result in an irreversible fatal reaction. (Tr. 1846-50, 3027, 3032). Due to the high risk to the patient, and the fact that the typical work environment for nurses involves many responsibilities and frequent distractions, CMC developed a series of safeguards to protect patients by minimizing the risk for errors. (Tr. 1846-50, GC-3). CMC's policy has evolved over time, including significant revisions after a near-miss incident in October 2012, which was years before the onset of union organizing activity and which similarly resulted in the primary nurse being discharged. (R-35-37, R-42).

The most critical of these procedural safeguards, and a safeguard that has been in place in every version of CMC policy, is the requirement of a final two-nurse verification at the patient's bedside to ensure that the right blood product is being administered to the right patient just prior to starting the transfusion. (Tr. 1863-65, 3056, R-74-75, GC-3). This consists of two nurses at the patient's bedside jointly confirming patient name and date of birth either verbally with the patient or by checking the patient's ID bracelet, and checking key information on the unit of blood, prior to hanging the blood. (GC-3). This two-nurse bedside verification process for administering blood products is fundamental knowledge that all nurses are taught in nursing school. (Tr. 3027; *see* R-47).

In addition, the two-nurse bedside verification has been the basic standard of care across the nursing profession for decades and every nurse who testified stated that this was the standard at CMC and at any other healthcare facility they had ever worked. (Tr. 1862-64, 3027-28; Ex. R-47). It has been listed as the National Standard of Care by the Joint Commission every year for the past several years, including most recently in 2016, and again in 2017. (Tr. 3065; Ex. R-48). In addition, CMC nurses are regularly trained on the Blood Product Administration protocols via the hospital's online training system, including in July 2016, just two months prior to the 9/11/16 incident. (Decision, p. 29, 32; R-49-52). This Policy also requires that nurses certify that they have performed the two-nurse bedside verification. (*Id.*).

It is undisputed that on 9/11/16, Ms. Marshall and Ms. Lamb knowingly and deliberately violated CMC policy, and placed the life of their patient in danger by failing to conduct the required two-nurse bedside verification before starting the blood transfusion<sup>2</sup>, after which both nurses falsified the medical record by certifying that they had done so. (R-19, R-20-A-B, R-4). CMC only became aware of this incident because the patient – who had received 22 previous blood transfusions at CMC and was knowledgeable about the proper procedure – complained to the charge nurse immediately afterward. (R-4). During the investigation into this incident, Ms. Lamb admitted that she never even entered the patient's room; that she understood the policy; that she knew it was wrong; and that she was sorry, (Decision, p. 15), while Ms. Marshall brazenly declared that she did not believe a two-nurse bedside verification was necessary and admitted that she made the choice to dispense with it. (Tr. 1303, 1312).

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<sup>2</sup> To the extent the ALJ focuses on the fact that Ms. Marshall individually verified the patient's identity at her bedside before the transfusion began is of no consequence and misses the point. (Decision, p. 18). CMC never contended that Ms. Marshall failed to perform her own solitary bedside verification, and this was not a basis for the decision to suspend/discharge. Instead the key point is that Ms. Marshall knowingly and willfully ignored the two-nurse bedside verification. Thus, the ALJ devotes much of her analysis to a point that was never controverted and never relevant to CMC's reason for suspension and discharge.

The overwhelming evidence in the record establishes that, except for the incident on 9/11/16, nurses at CMC have consistently been performing the required two-nurse bedside verification, and that CMC had no reason to believe that this was not the case when it made the decision to terminate Ms. Marshall and Ms. Lamb. First, it is a National Safety Standard that has been in place for decades and that is taught at every nursing school and used at every healthcare institution. (See Tr. 1862-64, 3027-28; Ex. R-47). Second, the Blood Transfusion Cards that are maintained in each patient's medical record and in CMC's Blood Bank records establish that ALL nurses have routinely and consistently certified to performing the two-nurse bedside verification before starting a blood transfusion. (See Tr. 3050; R-62, R-64, R-65, R-66, R-68, R-69, R-70, R-73, GC-5, GC-6). Third, other than on 9/11/16, no patient or patient advocate has ever complained about a failure to conduct the two-nurse bedside verification. (Tr. 3050). Fourth, the medical records establish that the patient who did complain about the incident on 9/11/16 (referred to as "Patient SF") received 22 blood transfusions involving up to 44 RNs at CMC, and the two-nurse bedside verification was performed in every instance except for the transfusion at issue. (R-7, R-8). Thus, Patient SF was well aware of the proper protocol and when only one nurse came to her bedside to start the transfusion on 9/11/16, she asked Ms. Marshall why there was no second nurse. (R-5, R-6). Instead of bringing in a second nurse in response to the patient's concern, and as required by policy, Ms. Marshall decided to forge ahead by starting the transfusion by herself in violation of policy and in callous disregard for the patient's safety and her legitimate concern with the lack of normal and necessary precautions being taken. (*Id.*).

During the employer's investigation into the 9/11/16 incident, several staff nurses were asked about failures to perform the two-nurse bedside verification, and none of them came forward with even a single specific instance in which any nurses (other than Marshall and Lamb

on 9/11/16) had failed to perform the required two-nurse bedside verification. (R-9). Some expressed uncertainty as to whether the proper protocols were followed by every nurse in every instance, but none could identify a single specific occasion where they knew the two-nurse bedside verification had not been performed – let alone indicated that there was a widespread practice of ignoring the final two-nurse bedside verification requirement. (*Id.*).

Nor was there any indication from members of the nursing peer review committee that noncompliance with this critical patient safeguard was part of the nursing culture at CMC. Instead, the objective nursing peer review committee members unanimously concluded that “most experienced, competent practitioners would have managed the case differently.” (R-15-16).

Finally, as set forth above, when Ms. Marshall and Ms. Lamb were interviewed regarding the incident, Ms. Lamb admitted that she never even entered the patient’s room; that she understood the policy; that she knew it was wrong; and that she was sorry (R-4, R-11), while Ms. Marshall brazenly declared she does not believe that a two-nurse bedside verification is necessary, and that she can determine on her own whether or not to follow the policy because she is fully capable of multitasking. (Decision, p. 15, R-5-6, R-19, R-20-A-B).

### **THE ALJ’S DECISION**

The ALJ disregards these core facts, finding that CMC’s decision to suspend and terminate Ms. Marshall and Ms. Lamb was instead “a ruse for its real motivation of removing Marshall’s vocal support for unionization.” (Decision, p. 2). In reaching this unsupported conclusion that is built upon a widespread conspiracy theory of inferred nefarious motives, and includes an unnecessary attack on Patient SF, the ALJ:

(1) relies on evidence, which does not exist, that the failure to perform the two-nurse bedside verification was a widespread practice (Decision, p. 23-29; 48-50);

(2) states that the four nurses interviewed during the investigation indicated this was a widespread practice, an assertion that is flat-out wrong (Decision, p. 20-23; 51);

(3) downplays the seriousness of the incident because no one was physically hurt, thus endorsing a No-Harm, No-Foul policy for blood transfusions, which is contrary to National Safety Standards, Nursing Profession Standards, Blood Bank Administration Standards, and NLRB law (Decision, p. 16, 50-51);

(4) faults CMC for gathering evidence concerning the patient complaint stemming from the 9/11/16 incident prior to interviewing Marshall and Lamb (Decision, p. 48);

(5) finds that the use of a nursing peer review committee to obtain an objective view of the seriousness of the misconduct was all a ruse calculated to terminate a union proponent (Decision, p. 31-32, 48);

(6) discounts the validity of Patient SF's complaint because the patient was in a stressful situation and was allegedly in a "dark place," even though she had the wherewithal to make a contemporaneous complaint to both Ms. Marshall and the charge nurse, and Ms. Marshall and Ms. Lamb admitted to the key elements of the patient's account (Decision, p. 47);

(7) finds that the termination was inconsistent with past discipline imposed by CMC despite the fact that the ALJ cannot point to single instance of deliberate falsification of medical records where the employee was not discharged, nor can the ALJ point to a single instance of willful violation of an established National Safety Standard and CMC policy with respect to a high-risk medical procedure where the employee was not discharged (Decision, p. 39-46);

(8) finds that CMC should have applied a policy known as the Just Cause Algorithm to the patient complaint, despite the undisputed evidence that the Just Cause Algorithm was intended to address situations involving staff-initiated complaints relating to confusion over certain policies; whereas here, there was no confusion over the two-nurse bedside verification

requirement, but instead, a policy that Ms. Marshall and Ms. Lamb understood, yet deliberately chose to violate (Decision, p. 17, 36-37);

(9) discredits the credibility of any witness whose testimony does not fit the ALJ’s “ruse theory” including rejecting testimony based on such tenuous grounds as (i) an individual being CMC’s representative and being able to hear other witnesses testify before her (Decision, p. 33); (ii) an individual inadvertently knocking over the microphone which the ALJ finds inconsistent with someone who is telling the truth (Decision, p. 11, fn. 17); and (iii) finding that a former employee, who last worked at CMC two years before the hearing, should not be credited because he could not remember the specifics of other CMC policies entirely unrelated to blood transfusions and not related to National Safety Standard requirements that are taught in every nursing school and used at every healthcare institution (*Id.*); and

(10) finds Ms. Marshall to be a credible witness on the basis that she was strong-willed, specifically citing Ms. Marshall’s refusal to call CMC management back while she was on vacation, while somehow inexplicably finding that CMC’s failure to speak to Ms. Marshall before she returned from vacation was further evidence of the “ruse” to terminate her; and despite the fact that Marshall admits to making false certifications in the medical record; her story shifted several times during the employer’s investigation and on the witness stand; and this so-called strong-will included flatly declaring that she knows better than the Joint Commission, the textbook on nursing practices (Lippincott), the medical doctor in charge of the blood bank, among others, on whether she needs to follow CMC policy (Decision, p. 12, fn 19).

These errors, and additional erroneous findings, are discussed in more detail below.

## **ARGUMENT**

### **POINT ONE**

#### **THE RECORD EVIDENCE ESTABLISHES THAT CMC NURSES HAVE CONSISTENTLY BEEN PERFORMING THE REQUIRED TWO-NURSE BEDSIDE VERIFICATION AND THE ALJ'S FINDINGS ON THIS SUBJECT SHOULD BE REJECTED**

The primary rationale underlying the ALJ's conclusion that Ms. Marshall and Ms. Lamb's violation of the final two-nurse bedside verification was not serious, is the mistaken and unsupported finding that ignoring this critical and final safeguard was a widespread practice.

##### **A. Overwhelming Evidence of Strict Compliance with the Two-Nurse Bedside Verification Requirement Other than During the 9/11/16 Incident**

Specifically, the ALJ contends that if "Ames or Raupers [CMC Management involved in the investigation] pursued the issue of whether the RNs truly knew and practiced the blood transfusion policy, they would have found, as became pellucid during the hearing, that the confusion and lack of full compliance with the transfusion policy was not isolated to Marshall, Lamb and the four RNs that Ames interviewed." (Decision, p. 23).

There is utterly no basis in the record evidence for this finding. During its investigation, CMC, and specifically, Ms. Ames, interviewed four RNs regarding the transfusion policy. Each nurse was careful to state that whenever they administered blood, they performed the two-nurse bedside verification, but that they couldn't speak for others.

The closest that any of these other nurses came to claiming that they themselves had neglected to perform the two-nurse bedside verification was Ananda Szerman, who gestured toward the nurses desk, possibly implying that the final verification is sometimes done there, or possibly in reference to the initial verification which normally does take place at the desk. However, even Ms. Szerman stopped short of actually stating that she had ever omitted the two-nurse bedside verification. Furthermore, when pressed by Ms. Ames, and specifically asked

whether her certifications on the Blood Administration Cards were inaccurate, Ms. Szerman answered no, meaning that her documentation was accurate, and thus acknowledging that her personal practice was to perform the final two-nurse verification at the bedside as attested to on the Blood Cards.

The ALJ's reasoning is that CMC should not have relied on actual responses from the four RNs interviewed because CMC should have known they did not want to get in trouble by admitting that this was a widespread practice, and therefore, they were lying in these investigatory interviews. (Decision p. 23-24). Thus, the ALJ imputes her own speculative assumptions into the minds of both the CMC investigators and the RNs, and relies on this as the basis for her finding and conclusion, which is clearly not an evidence-based finding supported by the record. *See Precoat Metals*, 341 NLRB 1137, 1145 (2004)(rejecting ALJ's rationale where it rested on conjecture, surmise, and speculation).

In addition, the ALJ ignored a wealth of relevant countervailing evidence in the record showing that: (1) there had been no reported incidents of violations of the policy; (2) Patient SF had received all of her previous transfusions at CMC in the same exact way using the two-nurse bedside verification; and (3) the two-nurse bedside verification procedure is the industry standard and is taught in every nursing school. Instead, the ALJ finds that none of this evidence was sufficient, and that CMC refused to really get to the bottom of the issue and dig further to find out that these four RNs were not being entirely forthcoming in their interviews – all in furtherance of its elaborate ruse – completely ignoring the notion that CMC wanted to genuinely make the right decision in response to a well-founded and serious patient complaint.

This is a ridiculous premise, particularly since, as set forth above, reinforcement of the double verification policy was necessitated by a near-miss incident in 2012, and all staff members involved in the blood transfusion process should have known of the seriousness of following the

policy and potential consequences for not doing so. CMC had no evidence to suggest, particularly at the time it made the decision to discharge Ms. Marshall and Ms. Lamb, that there were any violations of the two-nurse bedside verification policy, let alone that there was a widespread pattern of noncompliance. The only implication to that end came from Ms. Marshall who was being investigated for gross misconduct, and whose reasons for failing to comply with the policy were constantly shifting<sup>3</sup>, thus undermining her credibility, particularly in light of all other evidence showing that all other nurses were following the policy (*i.e.*, patient SF's numerous transfusions done correctly; hundreds of nursing certifications in the medical records; absence of any like incidents in the incident reporting system; Ms. Lamb admitting that she had made an error and knew she was in violation of the policy; and the statements of other staff nurses who were interviewed).

Frankly, the entire notion that a major medical center in today's regulatory environment could or would tolerate rampant disregard for vital clinical protocols among its professional nursing staff is patently absurd, as is the notion that nursing professionals themselves would routinely ignore patient safety standards and would deliberately falsify medical records. Yet this is what the ALJ found despite the absence of any evidence to support such an unrealistic conclusion.

#### **B. Overwhelming Evidence of Compliance With the Two-Nurse Bedside Verification Procedure After the Terminations and During the Hearing**

During the hearing, the General Counsel attempted to prove through several employee

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<sup>3</sup> Ms. Marshall and Ms. Lamb were made aware of the Patient SF's complaint on September 11, 2016, by Charge Nurse Scott Goldsmith. When Mr. Goldsmith spoke to them about the failure to perform the required two-nurse bedside verification, neither of them claimed that they were unable to follow protocol due to extenuating circumstances, nor did either claim that skipping the most crucial final safeguard in a high-risk medical procedure by dispensing with the two-nurse bedside verification was common practice among nurses in the ICU. We know this because Mr. Goldsmith's contemporaneous documentation of his conversations with Ms. Marshall and Ms. Lamb on 9/11/16 set forth in the incident report (Ex. R-4) says nothing about any such excuses and there was simply no basis for CMC to believe at the time it discharged Ms. Marshall and Ms. Lamb that the failure to follow the two-nurse bedside verification was a widespread practice.

witnesses that failing to follow the two-nurse bedside verification was a widespread practice, but if anything, their testimony was more notable for the admissions they made, than for supporting the false proposition of widespread reckless disregard for patient safety and rampant medical record falsification.

Nonetheless, the ALJ again chose to disregard any testimony contrary to her theory of a ruse, and credited only testimony that would tend to suggest violations of the two-nurse bedside verification may have occurred among other nurses in the past.<sup>4</sup> The ALJ then extrapolates from this unfounded conclusion that there was a widespread failure to comply with the two-nurse bedside verification at CMC. However, the obvious flaw in this is two-fold: (1) the overwhelming evidence established that CMC follow the two-nurse bedside verification and have always done so; and (2) the ALJ erroneously relies on evidence that individuals failed to follow other elements of the transfusion policy as evidence that employees were failing to follow the two-nurse bedside verification. (See Decision, p. 24-25, titled “Witness testimony establishes that failure to fully understand and comply with the transfusion policy was widespread”).

Tellingly, the ALJ fails to acknowledge the testimony of Nate Newman, Seth Mead, and AJ Barnes, who each provided strong and unwavering testimony that they, and every other nurse that they had worked with at CMC, went inside the room to perform the bedside check (Tr. 2491, 2541, 2780, 2786) and the ALJ discredits the same testimony by Laura Rothermel and Jennifer Cole because they did not check all the required items on the transfusion card while they were inside the room performing the bedside check. (Decision, p. 27-28). Again, the absurdity of this is clear. Failing to ever set foot in the room to verify the patient’s identity is far different from not allegedly checking every single item on the transfusion card while in the room before starting

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<sup>4</sup> For example, the ALJ chooses to discredit the testimony of Deborah Raupers that there was no evidence of other employees violating the policy on the tenuous grounds that: (1) as the employer representative, Ms. Raupers had the benefit of hearing others testify before her; and (2) she appeared nervous through her testimony “by rubbing a small rounded, smooth wooden cross like one would do with a worry stone.” (Decision, p. 33-34).

the transfusion. This is consistent with the ALJ's repeated attempts to bolster her theory of the case by making apples-to-oranges comparisons.

While choosing to ignore all of the testimony and records to the contrary, the ALJ instead relies on the following testimony to support her flimsy decision, but a close reading and review of even this testimony, shows that widespread noncompliance with the two-nurse bedside verification requirement did not exist at CMC:

(1) ICU nurse Mary Day testified that blood must be checked with another nurse (Tr. 68-69), and that it must be checked both at the desk and in the room with the patient. (Tr. 70). Ms. Day may have stated that she filled out the blood transfusion card out at the desk, but the important part is that she never actually performed the check outside the patient's room. (Tr. 86-87). All of Ms. Day's testimony relates to where she filled out the card rather than where the actual check was performed. Significantly, Ms. Day testified that "normally the other nurse [the second nurse performing the check] would either go in and take a look herself and then leave." (Tr. 97). This testimony explicitly shows that both the primary and secondary nurse check the blood inside the patient room at the bedside. Ms. Day testified that if she was the second nurse, not the primary nurse, "my practice would always be to walk into the room and verify for myself who it is." (Tr. 99, Tr. 105-106). She always entered the room and she did this "because we take safety very seriously." (Tr. 106-08, 114-15, 182-83, 305-07).

(2) ICU nurse Christine Monacelli testified that there were two checks, one at the desk "and then the two RN's go into the room and verifying the blood against the Patient's name band and asking them." (Tr. 342-43). Ms. Monacelli was very confused by all of the questioning about the blood checks, and she appeared to answer whichever way the question was asked. At one point she testified that "actually when I check blood and

follow that I always thought to be the exact policy and procedure as per Cayuga Medical Center took everything in the room” (Tr. 576), but then she immediately turned around and stated that she actually performed some checks out at the nurses station (Tr. 577). When pressed, Ms. Monacelli testified that as the secondary nurse she usually did go into the patient’s room but that she felt she was free to violate any care policy if she wanted to.<sup>5</sup> (Tr. 597, 600). Ms. Monacelli was evasive, consistently confused and commonly changed her recollection and answers, and there was no credible evidence that anyone but herself violated this policy (even if we assume that her own purported violations are believable). (Tr. 663-66). Furthermore, she conceded that no managers or supervisors knew about any blood transfusions done without a two-nurse bedside verification process prior to the 9/11/16 incident. (Tr. 684).

(3) ICU nurse Joan Lynn Tregaskis testified that she checked blood in the room, except in extremely rare circumstances. She testified that she could only recall about three times over the last 5 to 7 years when conditions caused a two-nurse bedside verification to not take place (Tr. 913, 925, 947-48, 977-78), but she acknowledged that none of these incidents were ever reported to management. (Tr. 943). Ms. Tregaskis also acknowledged that the final two-nurse bedside verification is the most critical step in the blood product administration process. (Tr. 921).

(4) Similar to Ms. Tregaskis, former ICU nurse Ananda Szerman testified that the two-nurse verification generally happened inside the patient room, but not always. (Tr. 1082-83, 1111, Tr. 1148-49). She could not provide any specifics as to the occasions when the two-nurse bedside verification did not occur, but did say that such events were never

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<sup>5</sup> This contention strongly undermines Ms. Monacelli’s credibility. Nurses are professional healthcare practitioners who are trained to strictly follow medical orders, as well as clinical procedures and patient safety protocols. Nurses are not doctors or policymakers and do not have the authority to make a personal choice to violate a clinical policy. Such a claim is insulting to the nursing profession.

reported. (Tr. 1132). Former Emergency Room nurse Louise McGarry only testified about what Amanda Szerman allegedly told her, rather than from any direct knowledge. (Tr. 1160-63). Ms. McGarry acknowledged that she was aware of the policy and the two-nurse bedside verification requirement, and she did not testify that she ever failed to abide by this policy. (Tr. 1165-66).

(5) ICU nurse Anita Tourville Knapp testified that in very busy or chaotic situations she remembered occasions where two nurses did not do the bedside check but these incidents were never reported. (Tr. 1705-06, 1724, 1732-33). Her regular practice when acting as the secondary nurse was to join the primary nurse in the patient's room for the final verification. (Tr. 1707-08). She testified on cross examination that the omission of a two-nurse bedside verification was rare and she could not recall any specifics. (Tr. 1728).

(6) Finally, RN Jacqueline Thompson testified that two-nurse bedside checks are generally performed, but she recalled one incident in the ICU when she thought Mr. Goldsmith was going to skip going in the patient room, but ultimately Mr. Goldsmith did go in the patient room to perform the two-nurse verification checks. (Tr. 1765-66, 1797). This was the only check she had done in the ICU and the two-side bedside verification check was performed, and she also testified that in every other unit she was assigned to they also complied with the two-nurse bedside verification process. (Tr. 1766-67).

When all of this testimony that the ALJ alleges supports her decision is viewed as a whole, it refutes, rather than supports, the contention that omitting the two-nurse bedside verification was common practice. A couple of these witnesses claimed that they knew of only a few occasions over a multi-year period when a failure to conduct the two-nurse bedside verification had occurred, but they could not provide any concrete details about any of these occasions, and they all conceded that to the extent any such occasions existed, they were few in

number, very rare, and never reported to anyone in management or to CMC's incident reporting system.<sup>6</sup>

Accordingly, there is no basis for the ALJ's contention that the failure to comply with the policy was widespread; the only conclusion that is supported by the overwhelming record evidence is the opposite – that nurses at CMC have consistently adhered to the final two-nurse bedside verification requirement, and to the extent there may have been rare instances where it was not adhered to, this was never reported to management.

CMC relied on the overwhelming evidence gleaned from extensive hospital records and from everyone else (*i.e.*, the patient, the patient's sister who happened to be a critical care nurse, the Charge Nurse, the other ICU nurses, and even Ms. Lamb), rather than Ms. Marshall's shifting explanations and unsupported claims, in concluding that the policy requiring a final two-nurse verification at the patient's bedside was being followed consistently throughout CMC, except in the case of the 9/11/16 transfusion administered by Ms. Lamb and Ms. Marshall.

The ALJ failed to provide any legitimate rationale for ignoring all of this evidence. Her finding that omitting the required two-nurse bedside verification was commonplace is not supported by substantial evidence and must therefore be rejected.<sup>7</sup> Because this serves as the

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<sup>6</sup> A couple of the General Counsel's witnesses pointed a finger at former ICU Director Shawn Newvine, claiming that he was involved in one or more occasions when the two-nurse bedside verification was omitted. However, Mr. Newvine (who left CMC two years prior to the hearing) testified pursuant to subpoena and forcefully rebutted these accusations. The ALJ discredited Mr. Newvine's testimony that performing a two-nurse bedside verification prior to a blood transfusion is "a well-known patient safety rule. It's published every year by the Joint Commission and the IHI. It's a national patient safety rule. It's just one of those golden rules you don't break." (Tr. 24 Tr. 2465-66, 2469-72). The ALJ disregarded all of this testimony. She said Mr. Newvine appeared "overconfident." She also faulted for Mr. Newvine for not remembering other aspects of his tenure at CMC, specifically "how many nurses are required to take narcotics out of the pyxis machine." (Decision, p. 26-27, fn. 29). The ALJ's explanation for rejecting Mr. Newvine's testimony is indefensible. He remembered and was confident about the all-important two-nurse bedside verification because, as he testified, this is a golden rule taught in nursing school, universally followed, and is a fixture among the annual National Safety Standards. The ALJ's speculation that maybe Mr. Newvine gave false testimony because he was worried about his reputation at his current employer is completely unfounded and should be rejected and again, only highlights, how far the ALJ was willing to go to disregard evidence that did not fit her "ruse" narrative.

<sup>7</sup> In her Decision, the ALJ erroneously takes the evidentiary principle that "the document speaks for itself" and literally turns that principle on its head by disregarding the plain contents of the printed language on CMC's Blood Transfusion Card where it explicitly states that the two-nurse verifications must be performed at the bedside,

primary reason for her determination that the discharges were a “ruse,” the ALJ’s decision must be overturned.

## **POINT TWO**

### **CONTRARY TO THE ALJ’S FINDING, CMC’S DECISION TO DISCHARGE MARSHALL AND LAMB IS FULLY SUPPORTED BY PAST PRACTICE**

Ms. Marshall and Ms. Lamb were each guilty of committing two separate acts of severe misconduct: first, intentionally violating CMC policy and a National Safety Standard with respect to the most critical patient safeguard during a high-risk medical procedure by making a choice, in Ms. Lamb’s case, to not even enter the patient’s room, and by making a choice in Ms. Marshall’s case to proceed without following protocol despite the patient’s expressed concern over the lack of normal safety precautions; and second falsely certifying in the medical record that the required two-nurse verification process took place at the patient’s bedside.

#### **A. Employees Who Engaged In Similar Acts of Misconduct in the Past Have Similarly Been Immediately Discharged**

Although no previous case at CMC is exactly like the serious misconduct committed by the two nurses responsible for the 9/11/16 incident, the evidence shows that employees who engaged in similar acts of misconduct were promptly discharged by CMC upon discovering such misconduct, and the ALJ’s attempt to distinguish these cases should be rejected:

- On May 12, 2009, RN M. Whitford was immediately discharged for falsification of records by entering test results without actually having conducted the tests. (Ex. R-30) (Decision, p. 43)

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characterizing this section of the document as somehow being “embedded”. The ALJ then proceeds to credit the testimony of various witnesses who made the patently absurd claim that they never noticed the wording in this part of the document, stating that, “I credit their testimony that they were not aware that this specific language was embedded in the transfusion card.” In other words, instead of discrediting witness testimony purporting to not notice what the document said, even though it was their professional responsibility to understand clinical forms and to fill them out accurately, the ALJ specifically credits their testimony that they somehow did not notice what the document said. This is a blatant example of the ALJ’s bias and her result-oriented analysis, twisting and stretching the evidence, to fit her “elaborate ruse” theory of the case.

- On September 24, 2009, RN D. Noonan was immediately discharged for falsification of records related to crash cart documentation. (Ex. R-31) (Decision, pp. 45-46).
- On December 10, 2015, Hospital Aide J. McDonald was immediately discharged for failing to weigh a patient and falsifying the patient record by entering fictional weight(s). Although Ms. McDonald had a history of prior disciplinary problems, these were unrelated and less serious than the failure to weigh/falsification which prompted her immediate discharge. (Ex. R-32) (Decision, p. 49-50).
- On February 16, 2016, Hospital Aide R. Smith-Parris was immediately discharged when it was discovered that she had entered false blood pressure readings on multiple patient records. (Ex. R-33) (Decision, p. 43).
- On June 23, 2016, RN V. Comstock was immediately discharged for failing to conduct various checks before administering a medication, including failing to scan the patient bracelet. (R-34) (Decision, pp. 44-45).

Despite serving CMC with extensive subpoenas for records, the General Counsel and the Charging Party failed to uncover any evidence of a case in which immediate discharge did not result for a nurse or other employee who engaged in, either intentional violation of a National Safety Standard, or deliberate falsification of a medical record, much less both. In addition, there is no evidence of any report of a violation of the two-nurse bedside protocol, without an immediate discharge, and the ALJ therefore does not and cannot point to one such example in her decision.

Despite failing to provide any evidence of a similar case in which an immediate discharge did not result for a nurse or other employee who engaged in either, intentional violation of a National Safety Standard, or intentional falsification of medical record, the ALJ inexplicably, asserts, without citing to any record evidence (because no such evidence exists), that “CMC is tolerant of employees committing a significant amount of what can only reasonably be determined to be intentional inaccurate documentation before discipline results.” (Decision, p.

10).

**B. The ALJ's Citation to Instances Where Employees Failed to Fully Complete Blood Transfusion Cards As Comparable Evidence Must be Rejected**

After failing to meaningfully distinguish the above prior instances of discipline at CMC, the ALJ inexplicably cites to 28 incidents where nurses who failed to fully complete the transfusion cards were not discharged. (Decision, p. 44-45).

It should go without saying, but the failure to fully complete a transfusion card due to error, oversight, or distraction is not remotely similar to deliberately ignoring and failing to perform the final critical safeguard in the blood transfusion process and then proceeding to falsely certify on the transfusion card that the check was completed. This section only further clarifies that the ALJ cannot cite to one comparable instance of misconduct where an employee was not discharged, and the ALJ's attempt to compare a failure to completely fill out the transfusion card as being similar to Ms. Marshall and Ms. Lamb's misconduct, shows how far the ALJ was willing to go to reach her desired finding, even if the evidence clearly did not support it.

**C. The Other Instances Cited by the ALJ are Distinguishable Because None Involve Willful Violations or Deliberate Falsifications and they Did Not Involve the All-Important Final Safeguard Against A Potentially Fatal Transfusion of the Wrong Blood Product**

It is undisputed that nurses are human; and that humans sometimes make errors; and that this is particularly true in the work environment of an acute care facility which is typically very dynamic and stressful. The evidence establishes that thousands of incidents are reported through CMC's Incident Reporting System every year. In addition, it is important to note that not all deviations from policy are the same.

The ALJ cites numerous minor instances involving medication errors, errors in documentation, and various incidents where nurses made mistakes at CMC that did not result in discipline or discharge. What the ALJ failed to show, however, is that any of these other

instances involved a deliberate, purposeful and knowing violation of CMC policy and National Safety Standard, as opposed to unintentional mistakes that can occur for any number of reasons. We know that Ms. Marshall's decision to disregard the two-nurse bedside verification was a matter of deliberate choice on her part because she admitted to making this choice despite Patient's SF's expressed concerns over why this transfusion was not being done according to the normal safety protocol. None of the other cases relied upon by the ALJ involve this type of deliberate decision to commit a serious patient safety violation.

The fact that other incidents may have involved giving a wrong dose of medication by accident, or even skipping a step in procedure, does not mean that the violation was willful since mistakes like this can and do happen due to other factors, such as an equipment issue with a scanner, or emergent conditions such as can sometimes occur in the Emergency Department, or because of stress, distraction or plain forgetfulness; yet nothing like this accounts for the behavior of the two responsible nurses in the 9/11/16 incident.

In addition, the ALJ specifically recognized that the NLRB in *Jackson*, 355 NLRB 643, 645 (2010), "cited the heightened danger in blood transfusions in comparison to improperly medicating patients as a legitimate reason for the employer to have treated the RNs involved in the blood transfusion differently than other RNs who had made errors in medicating patients" (Decision, p. 50), yet, dismissed its application here. Board precedent recognizes that blood transfusion errors cannot be treated the same as other errors in a healthcare institution, because an error regarding blood product will almost always result in immediate death. Shortcuts cannot be allowed, and evidence of past practice regarding unrelated and different violations of CMC policy are irrelevant to CMC's necessary decision to discharge Ms. Marshall and Ms. Lamb.

#### **D. The ALJ's Focus on Prior Discipline in Other Discharge Cases is a Red Herring**

As discussed above, CMC has a consistent past history of immediately discharging any nurse or other staff member who it learns has falsified a medical record, as well as having discharged the nurse who hung the wrong blood in the October 2012 incident. In some of these cases, the employees who were discharged also had one or more prior disciplinary actions in their file; however, this does not prove that they would not have been discharged in the absence of such prior disciplines, nor is there any basis for making such an inference since those cases where no prior disciplines existed also resulted in immediate discharge for the falsification. Furthermore, CMC managers testified that falsification of a medical record is always considered grounds for immediate discharge without regard to the employee's prior record because it is unlawful, unethical and inherently dangerous to falsify medical. Accordingly, the ALJ's reliance on this evidence is misplaced.

### **POINT THREE**

#### **THE ALJ'S NO-HARM NO-FOUL STANDARD AS APPLIED TO BLOOD TRANSFUSIONS CANNOT BE ENDORSED**

The ALJ's other significant reason for refusing to uphold the discharges is that the patient was not harmed. Indeed, the ALJ states that CMC, and in particular Ames, Crumb and Raupers, exaggerated the severity of the situation. (Decision, p. 17). This finding ignores the testimony of CMC's lead witness, Dr. Sudilovsky, chairman of the pathology laboratory medicine and director of the laboratories, who represented to Raupers that "he would no longer authorize the staff involved [Marshall and Lamb] to perform blood transfusions" (Decision, p. 30), as well as evidence that the final two-nurse bedside verification was taught in nursing school and is a National Safety Standard.

Additionally, the ALJ distinguishes the Board's decision in *Jackson Hospital Corp.*, 355 NLRB 643, 645 (2010), by finding that the primary difference was that "most strikingly, patient SF was given the correct unit of blood." (Decision, p. 50). We respectfully request that the Board, as it did in *Jackson Hospital Corp.*, 355 NLRB 643, 645 (2010), find that potential life-threatening errors relating to blood transfusions must be met with the severe consequence of discharge, regardless of whether or not the misconduct actually results in harm to the patient.

First, it is wrong to assert that the patient suffered no harm. Harm is not limited to physical injuries, and the patient's own account makes clear that she was distressed and felt vulnerable in her bed as a result of Ms. Marshall's abrupt, dismissive and patently unsafe behavior with respect to the 9/11/16 blood transfusion. Indeed, although Patient SF sadly became too sick to testify herself by the late stages of the hearing in this case, her sister Star York did testify about the 9/11/16 incident, and she became visibly emotional over the fact that her sister had to suffer additional stress over this incident on top of having to deal with all of the stress caused by her disease.

Second, and more importantly, the severity of Ms. Marshall and Ms. Lamb's conduct was not, and cannot, be judged by the outcome to the patient. In *Jackson*, the wrong blood was hung but the patient survived by luck and was not severely harmed. Similar to disciplining those nurses, the point here is that both nurses' behavior exhibited a reckless disregard for patient safety and for this patient's life, making it much more likely that a catastrophic event could have occurred. Hospitals cannot afford to wait for reckless staff members to kill a patient before taking action, and just because Ms. Marshall happened to hang the right blood for Patient SF, this does not justify or excuse Ms. Marshall and Ms. Lamb's deliberate refusal to follow CMC policy.

In addition to endorsing a No-Harm, No-Foul policy, the ALJ, as set forth above, attempts to downplay the seriousness of the misconduct by repeatedly declaring all testimony that non-

compliance with one of the most basic and necessary safeguards for blood transfusions about the dire possible effects of this incident to be “contrived” or “partially contrived.” (Decision, p. 17, 31). In fact, despite the ALJ acknowledging that blood transfusions errors can result in immediate death, and that the final bedside check is the last procedure to ensure the proper blood product is administered, she nonetheless finds “the testimony solicited from Sudilovsky (Chairman of the Pathology Laboratory of Medicine and Director of Laboratories) about the dire possible effects of this incident partially contrived.” (Decision, p. 31). Again, the ALJ would have required that the wrong blood actually reach the patient before finding any wrongdoing worthy of misconduct.

To further support her theory that this incident was not as serious as CMC contends, the ALJ refused to enter evidence, in clear error, that the New York Education Department’s Office of the Professions had made a determination that Marshall and Lamb’s conduct warranted prosecution. (Proposed Exhibits R-71, R-79). The proposed evidence provided that only in cases where there is sufficient evidence of misconduct does a case get referred to the prosecution arm of NYSED, it is the equivalent of probable cause for an arrest. However, the ALJ refused to enter this evidence, consistent with her actions of refusing to acknowledge anything not fitting with her “ruse” theory of the case. In doing so, the ALJ was saved from having to discredit yet another independent source with absolutely no reason to falsify or act on behalf of CMC. The NYSED found, at least preliminarily, what all other individuals tasked to review the nurses’ misconduct had, that the knowing failure to comply with a National Safety Standard is an error that no nurse should make, showing that there is nothing contrived or partially contrived regarding the seriousness of this incident.

## **POINT FOUR**

### **THE ALJ'S FINDING REGARDING PATIENT SF'S EMOTIONAL STATE IS UNWARRANTED AND SHOULD BE DISREGARDED**

The ALJ attempts to rely on minor discrepancies over the respective witness accounts of exactly who said what in the patient's room on 9/11/16 or immediately after when Mr. Goldsmith came into the room.<sup>8</sup> From the beginning, CMC had no reason whatsoever to doubt the patient's account of what occurred in her room on 9/11/16. Patient SF had no reason to target Ms. Marshall or twist the facts as to what occurred. Yet, the ALJ implicitly, if not blatantly, disregards Patient SF's claim because she "was in a dark place" and scared for her life. (Decision, at p. 47). The ALJ's finding in this regard is insulting, and discounts the fact that a patient with extensive blood transfusion experience knew the required protocols, and also knew the significance of having the wrong blood transfused. Again, under the ALJ's "ruse" theory, the patient who initiated this complaint was somehow complicit in her imagined conspiracy to terminate Anne Marshall. Furthermore, the admissions of Ms. Marshall and Ms. Lamb corroborate the essence of the patient's account that only one nurse was present when her blood transfusion started. By proceeding to denigrate the patient's reliability on the flimsy notion that "she was in a dark place" was unnecessary, unsupported by any record evidence, and revealing of the ALJ's manifest bias.

In addition, CMC had no reason to doubt the account by Patient SF's sister Star York. Again Ms. York had no reason to target Ms. Marshall or twist the facts. Furthermore, the contemporaneous written account by the Charge Nurse Scott Goldsmith as set forth in the

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<sup>8</sup> In rejecting Mr. Goldsmith's testimony to the extent it was inconsistent with Ms. Marshall's, the ALJ continues her rejection of testimony on tenuous grounds, this time finding that Mr. Goldsmith could not be trusted because he also appeared nervous, so nervous in fact that "he knocked the microphone off the witness stand once, and almost did so again, even after it was repositioned away from him." (Decision, p. 11, fn. 17) . The ALJ's interpretation of this was that this uneasiness was "paradoxical with the expected demeanor of an employee who was honestly testifying on his employer's behalf. (*Id.*). These ridiculous leaps of logic are found whenever the ALJ seeks to discredit a CMC witness, or any witness providing testimony inconsistent with her theory, and should be rejected.

incident report is consistent with the accounts provided by the patient and her sister. These three contemporaneous accounts corroborate one another in all material respects. The three witness statements do not match one another word-for-word, because they were each told from their respective individual perspectives/memories. Such minor differences in witness accounts actually enhance the credibility and reliability of those accounts because they reflect an honest non-scripted telling by each witness of what they individually recall having occurred.

In contrast, Ms. Marshall had every motive to shape her account of what occurred in Patient SF's room on 9/11/16 so as to present her conduct in the most favorable light possible. Not only did Ms. Marshall have the obvious motive to misrepresent the facts, but her story about the 9/11/16 incident shifted several times as revealed in the transcript of her taped investigatory interview.

Significantly, despite giving Ms. Marshall and Ms. Lamb a pass on their reckless disregard for patient safety because they were often busy during their shift (*see, e.g.*, Decision p. 25), the ALJ found something nefarious regarding Mr. Goldsmith's failure to file an incident report that same day because he was busy during the shift. (Decision, p. 14-15). Again, the ALJ's findings are clearly not supported by substantial evidence.

Finally, the ALJ rejects the significant of Marshall's abhorrence to Patient SF's expressed concern because "Respondent did not provide any evidence that it has issued any discipline as a result of a patient's complaint about a staff member's dismissive attitude, lack of bedside manner, failure to ease a patient's concerns, or failure to follow procedure." (Decision, p. 16). First, as set forth above, there were numerous instances where discipline was imposed for failure to follow proper CMC procedure, so this should be disregarded; second, the only basis for the ALJ's finding regarding the dismissive attitude, is that "Respondent's intentionally omitted evidence concerning this issue. Therefore I conclude that Marshall's failure to ease patient SF's concerns

about her safety and/or her dismissive attitude that resulted in the patient complaint was not a basis for which Respondent would have disciplined or discharged her.” (*Id.*). Although attempting to follow this logic is difficult, the ALJ is essentially making an adverse finding based on an assumption that CMC omitted existing past practice evidence, while choosing to ignore the more likely and logical possibility that no such evidence existed because Marshall’s dismissive attitude toward the patient in the face of the patient’s stated concern was entirely unprecedented. This also ignores that it is the General Counsel’s burden of proof and the General Counsel was unable to uncover any past practice evidence that would support this absurd theory. Accordingly, the lack of any comparable evidence of a nurse committing serious misconduct while simultaneously disregarding the concerns of a patient is not in the record because no such comparable evidence of such misconduct exists.

#### **POINT FIVE**

#### **THE ALJ’S FINDING THAT CMC SHOULD BE FAULTED FOR THOROUGHLY INVESTIGATING THIS MATTER AND THE MANNER IN WHICH THE INVESTIGATION WAS CONDUCTED SHOULD BE DISREGARDED**

The ALJ attempts to fault CMC for nearly every aspect of its investigation, including the unsupported finding that after learning of the 9/11/16 incident, “CMC embarked on an unprecedented investigation of the matter.” (Decision, p. 7). However, this is entirely unsupported by the record, and there is no evidence to support that CMC failed to investigate other patient complaints or that this investigation was unprecedented in any way.

The ALJ’s first example of an “unprecedented” and flawed investigation was that fact-gathering was conducted before reaching out to Ms. Marshall or Ms. Lamb. However, this simply ignores that CMC attempted to contact Ms. Marshall numerous times while she was on vacation. (Decision p. 49). We remind the Board that the ALJ was impressed by Ms. Marshall’s refusal to answer CMC’s phone calls while she was on vacation, concluding that this showed a

“strong-will.” Nonetheless, the ALJ at the same time states that the failure to reach out to Marshall before she returned showed that the investigation was rigged by waiting until Ms. Marshall’s return, thus highlighting the twists the ALJ makes throughout her flawed decision.

In addition, the ALJ’s misunderstanding of how to properly conduct a workplace investigation is laid out plainly in her suggestion of how she would have preferred this be handled. Specifically, the ALJ states that since CMC knew about the incident on September 12, rather than engaging in an investigation into the facts, CMC should have gone to Ms. Marshall and Ms. Lamb first to let them know that they were being investigated and to simply request their position on the matter at that time. (Decision, p. 48 (“Management was aware of the incident on the morning of Monday, September 12. Instead of immediately contacting Marshall and Lamb before Marshall left on a planned vacation to ask them to explain the events, CMC set forth on a mission to develop a case against them”)). It would have been foolish and contrary to normal investigatory practices to interview a witness before sufficient facts are uncovered to see if an interview is even warranted, and to better understand the nature of the complaint and the surrounding circumstances. (Decision, p. 48). This is not how the investigation played out, and as the investigation progressed, it had become clear that there was little that could have justified the two nurses’ conduct, which is what ultimately led to the early drafting of discharge letters, as set forth below.

The ALJ also found that CMC’s use of a nursing peer-review committee to evaluate the nurses’ conduct is evidence of an inconsistent investigation and part of the “ruse.” However, it is hard to imagine how being extra careful and ensuring that this was in fact a serious violation of policy that no other nurse would have similarly violated, is somehow evidence of wrongdoing on CMC’s part. CMC was aware that it was confronted with gross misconduct by a union proponent who was litigious, and the fact that CMC administrators took extra steps to ensure a just result is

the sign of a responsible employer rather than some nefarious ruse. The ALJ's "you're damned if you do, damned if you don't" analysis on this, and many other points, is blatantly flawed and should not be accepted or condoned by the Board.

For example, the ALJ next finds CMC's investigation into the 9/11/16 incident was insufficient because many staff nurses were not interviewed about their practice with respect to the two-nurse bedside verification, and CMC should have dug deeper to uncover that there were other instances of employees not following the two-nurse bedside verification.

This argument ignores the fact that CMC did speak with several nurses and none of them came forward with a concrete example of even a single instance in which the two-nurse bedside verification was not performed. Since two nurses are always involved in blood product administration, these nurses not only spoke for themselves but for every other nurse who they had ever performed a blood transfusion with. It was not necessary or reasonable to expect that CMC would interview hundreds of nurses about this, particularly since CMC did review many hundreds of nurses' attestations on the Blood Transfusion Cards that they had carried out the two-nurse bedside verification, and since an examination of CMC's Incident Reporting System showed no reports of any failure to perform the two-nurse bedside verification going back as far as October 2012, not to mention that the importance of this critical patient safeguard is taught in Nursing 101, Lippincott, National Safety Standards, CMC policy and CMC training.

In sum, the ALJ's findings that the investigation was unprecedented and evidence of a "ruse" seeking to discharge Ms. Marshall is unsupported by the record evidence and should be rejected.

## **POINT SIX**

### **THE ALJ'S FINDING THAT DRAFT TERMINATION LETTERS AND DRAFT PUBLIC STATEMENTS PRE-DATING MS. MARSHALL'S OCTOBER 4 INTERVIEW WERE EVIDENCE OF THE RUSE IS AN UNSUPPORTED INFERENCE**

As discussed above, from the very beginning CMC was immediately confronted with two realities: (1) a serious patient complaint about the intentional violation of a National Safety Standard and a critical patient safeguard in a high-risk medical procedure; and (2) the fact that one of the responsible nurses happened to be a highly vocal union proponent who commonly shared information with the local media and was the subject of previous unfair labor practice charges. As also discussed above, CMC had no reason to doubt the patient's account of what happened, nor the corroborating account from her sister who happened to be a critical care nurse.

Furthermore, from early on in the investigation, CMC had the contemporaneous report from the Charge Nurse, as well as Ms. Lamb's admission that she never entered the patient's room despite certifying in the medical record to the two-nurse bedside verification, and that she knew it was wrong. CMC was also in the process of examining all of its records in the blood bank and in the incident reporting system. The only reason it took so long to close the investigation by completing Ms. Marshall's interview was that Ms. Marshall had left on an extended vacation and had not returned any of the telephone voice messages that CMC left for her.<sup>9</sup>

In the meantime, CMC already knew that the nature of the offenses warranted immediate discharge<sup>10</sup>, which is why the Human Resources office began to work on draft termination letters; and CMC also knew that the need to discharge Ms. Marshall would almost certainly generate a

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<sup>9</sup> Again to reiterate, inexplicably the ALJ lauded Ms. Marshall for this failure to call back management while on vacation as proof of her strong-will which the ALJ said contributed to her conclusion that Marshall was a credible witness. This reasoning goes beyond being illogical since there is no rational connection between refusing to return your employer's phone calls and the credibility of a witness's testimony. (Decision, p. 12, fn. 19).

<sup>10</sup> To the extent the ALJ relies on the hiring of travelers as further evidence of some plan to terminate Ms. Marshall and Ms. Lamb, such reliance is misplaced. (Decision, p. 20). Travelers were needed to cover during the period of interim suspension, not as permanent replacements for Ms. Marshall or Ms. Lamb.

great deal of controversy both internally and in the local public community, and would almost certainly result in further unfair labor practice charges, which is why the Public Relations office began to work on draft messages in advance of when they would likely be needed.

The ALJ's reasoning that the existence of these early drafts undermines the employer's investigation and establishes that the investigation was nothing more than a witch hunt flies in the face of the core undisputed facts at the heart of this case: the discharges resulted from a patient generated complaint that revealed an intentional and obvious violation of a CMC policy, National Safety Standard, a critical patient safeguard in a high-risk medical procedure, as well as falsification of the medical records. No hospital in America would tolerate such behavior from its professional nurses.

#### **POINT SEVEN**

#### **THERE IS NO BASIS FOR THE ALJ'S FINDING THAT THIS VIOLATION SHOULD HAVE BEEN ADDRESSED UNDER CMC'S JUST CULTURE ALGORITHM**

CMC has instituted a "Just Culture Algorithm" which, as the ALJ recognizes, is intended to encourage staff to report incidents so that safety issues can be addressed." (Decision, p. 17, 36-37). The Just Culture algorithm is intended to analyze conduct arising from confusion relating to a policy and to uncover and prevent future incidents through re-education. (Decision, p. 24, fn. 25, R-58). The ALJ disregards that the 9/11/16 incident had nothing to do with a failure of education or confusion regarding a policy. When Ms. Marshall was literally confronted by the patient herself, Marshall dug in her heels and started the transfusion without verification by a second nurse at the bedside, and Ms. Marshall later told CMC that she disagreed with policy and it was up to her to decide whether or not to follow the policy. When first confronted with the patient complaint, Ms. Lamb immediately feared that her license to practice nursing was in jeopardy. Ms. Marshall and Ms. Lamb both admitted that they understood the policy, yet both

nurses admittedly refused to follow the policy. Accordingly, the Just Culture algorithm is not relevant here, and the ALJ's second-guessing of CMC and the ALJ's opinion that re-education should have been the result of this investigation, is unsupported by evidence or even a basic understanding of managing a responsible healthcare institution.

### **POINT EIGHT**

#### **THE ALJ'S FINDING OF ANTI-UNION ANIMUS IS UNSUPPORTED BY THE RECORD EVIDENCE**

The ALJ erroneously finds anti-union animus by relying heavily on CMC statements that are protected by Section 8(c) of the NLRA. Specifically, the ALJ finds that a "flyer listing what CMC perceives as being the negative effects and cost of unionizations for employees" as evidence of anti-union animus. (Decision, p. 5)

There is no contention that this flyer was unlawful, and providing such information to employees is squarely within an employer's Section 8(c) free speech rights, and cannot be used to establish anti-union animus. Section 8(c) itself states clearly that "the expressing of any views, argument, or opinion, or the dissemination thereof, whether in written, printed, graphic, or visual form, shall not constitute or be evidence of an unfair labor practice under any of the provisions of this Act, if such expression contains no threat of reprisal or force or promise of benefit." *See also Toll Mfg Co.*, 341 NLRB 832, 142 (2004). Accordingly, such statements cannot be used to establish anti-union animus.

## **POINT NINE**

### **THE ALJ'S FINDING THAT CMC VIOLATED THE ACT BY REMOVING UNION LITERATURE FROM A RESERVED BULLETIN BOARD IS UNSUPPORTED BY THE CREDIBLE RECORD EVIDENCE**

The ALJ also found that CMC violated Section 8(a)(1) of the Act by one of its supervisors/agents removing a piece of union literature that was posted on a CMC bulletin board in or about July 2017. (Decision, p. 6).

Jacqueline Barr, a CMC supervisor, credibly testified that she took down all postings not sponsored by CMC, whether they be pro-union or anti-union on a bulletin board that was not intended for employee postings but reserved only for authorized employer postings (Tr. 2878-2880), and directed all the parties to post on other bulletin boards not reserved to management.

The credible evidence establishes that CMC has maintained two separate types of bulletin boards throughout the Medical Center. The small fabric bulletin boards adjacent to the time clocks have always been exclusively reserved for official CMC business, including such items as statutory notices to employees, information about employee benefits, and memoranda from senior leadership on various topics (referred to as “reserved bulletin boards”). Other bulletin boards located in break rooms and a public bulletin board near the cafeteria are open for employee use to post non-work related material, such as advertisements for dancing lessons, used cars for sale, apartments for rent, etc., as well as many union-related notices that have been posted and that CMC has allowed to remain (referred to as “open bulletin boards”). (Tr. 2880 - 84).

Ms. Barr testified that she did remove a union posting from a reserved bulletin board adjacent to the time clock by the elevator on the 3<sup>rd</sup> floor, which is a small fabric board reserved exclusively for CMC notices. Ms. Barr testified that Ms. Marshall saw her do this and questioned her right to remove the union flyer, to which Ms. Barr responded that no non-work related

materials were allowed on this particular bulletin board since it is used for official CMC notices and was not in an area such as the break room. (Tr. 2879-83).

Ms. Barr testified that Exhibit R-77 consists of two photographs that she took of the particular reserved bulletin board by the timeclock and elevator on the 3<sup>rd</sup> floor, and a third photograph that she took showing one of the large cork open bulletin boards where employees can post any material, including union-related notices that are not removed. (Tr. 2890-94).

The only evidence offered by the General Counsel in support of this claim and inexplicably relied upon by the ALJ was testimony by Ms. Marshall and a close-up or zoomed-in photograph taken by Ms. Marshall at least a week later purportedly showing the same bulletin board with some non-work related postings, including what appears to be an anti-union posting. (Ex. GC-34).

The photograph taken by Ms. Marshall is clearly of a different much larger cork bulletin board, and there should be no dispute over this. It is not the same reserved bulletin board that Ms. Barr removed a non-work related posting from on the occasion in question in July 2016. Ms. Marshall's photograph appears to show one of the open bulletin boards where non-work related notices are allowed. Ms. Barr testified that she was absolutely positive that the bulletin board shown in GC-34 (Marshall's photograph) is not the same bulletin board where she removed an item and was confronted by Ms. Marshall, because the two bulletin boards are made of different material and are a different size. (Tr. 2885-87).

Because the policy was consistently enforced, and employees had plenty of other places to post both pro-union and/or anti-union postings, there was no basis for this finding. Contrary to the ALJ's unsupported conclusion that employees should have the right to post on whatever bulletin board they like across the entire facility, those cases primarily involve union literature in break rooms, and have nothing to do with postings. (Decision, p. 7). In addition, the cited

portion of the ALJ's decision in a prior case involving CMC does not address the specific bulletin boards at issue. These bulletin boards at issue here were not in employee break rooms, and it was appropriate, and consistent with well-established Board law for CMC to maintain a bulletin board for employer postings only. *Register- Guard*, 351 NLRB 1110, 1114, 1118 (2007) (an employer is under no obligation to permit employees to use its bulletin boards). Accordingly, the ALJ's bulletin board finding should also be overturned.

### **CONCLUSION**

For the reasons set forth above, CMC respectfully submits that the ALJ's determination that Ms. Marshall and Ms. Lamb were suspended/terminated because of anti-union animus and that the employer unlawfully removed pro-union postings should be overturned.

Dated: March 5, 2018

Respectfully submitted,

BOND, SCHOENECK & KING, PLLC

A handwritten signature in black ink, appearing to read 'R. J. Pascucci', followed by a horizontal line.

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